Senate Bill No. 51

Passed the Senate September 9, 2011

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Secretary of the Senate

Passed the Assembly September 9, 2011

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2011, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Sections 1367.001 and 1367.003 to the Health and Safety Code, and to add Sections 10112.1 and 10112.25 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 51, Alquist. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law prohibits a health care service plan from expending for administrative costs, as defined, an excessive amount of the payments the plan receives for providing health care services to its subscribers and enrollees.

Existing law provides for the regulation of health insurers by the Department of Insurance. The Insurance Commissioner is required to withdraw approval of an individual or mass-marketed health insurance policy if the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged, as specified.

The federal Patient Protection and Affordable Care Act prohibits a health insurance issuer issuing health insurance coverage from establishing lifetime limits or unreasonable annual limits on the dollar value of benefits for any participant or beneficiary, as specified. The act also requires a health insurance issuer issuing health insurance coverage to comply with minimum medical loss ratios and to provide an annual rebate to each insured if the medical loss ratio of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified.

This bill would require health care service plans and health insurers to comply with the requirements imposed under those federal provisions, as specified. The bill would authorize the Director of the Department of Managed Health Care and the Insurance Commissioner to promulgate regulations and emergency regulations to implement requirements relating to medical loss ratios, as specified.

Because a willful violation of those requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.001 is added to the Health and Safety Code, to read:

1367.001. (a) To the extent required by federal law, every health care service plan that issues, sells, renews, or offers contracts for health care coverage in this state shall comply with the requirements of Section 2711 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued under that section, in addition to any state laws or regulations that do not prevent the application of those requirements.

(b) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 2. Section 1367.003 is added to the Health and Safety Code, to read:

1367.003. (a) Every health care service plan that issues, sells, renews, or offers health care service plan contracts for health care

coverage in this state, including a grandfathered health plan, but not including specialized health care service plan contracts, shall provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health care service plan on the costs for reimbursement for clinical services provided to enrollees under such coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(b) Every health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(c) (1) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the following:

(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health care service plan shall provide any rebate owing to an enrollee no later than August 1 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(d) (1) The director may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government

Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(2) The director may also adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(e) The department shall consult with the Department of Insurance in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

(f) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.

(g) Nothing in this section shall be construed to apply to provisions of this chapter pertaining to financial statements, assets, liabilities, and other accounting items to which subdivision (s) of Section 1345 applies.

(h) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with

Section 12739.5) of Division 2 of the Insurance Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 3. Section 10112.1 is added to the Insurance Code, to read:

10112.1. (a) To the extent required by federal law, every health insurer that issues, sells, renews, or offers policies for health care coverage in this state shall comply with the requirements of Section 2711 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued under that section, in addition to any state laws or regulations that do not prevent the application of those requirements.

(b) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5)), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 4. Section 10112.25 is added to the Insurance Code, to read:

10112.25. (a) Every health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, but not including specialized health insurance policies, shall provide an annual rebate to each insured under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health insurer on the costs for reimbursement for clinical services provided to insureds under such coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health insurer offering coverage in the large group market, 85 percent.

(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.

(b) Every health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:

(1) With respect to a health insurer offering coverage in the large group market, 85 percent.

(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.

(c) (1) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the following:

(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health insurer shall provide any rebate owing to an insured no later than August 1 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(d) (1) The commissioner may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(2) The commissioner may also adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial

adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(e) The department shall consult with the Department of Managed Health Care in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

(f) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.

(g) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5)), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 2011

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Governor